

ENFIELD ADULT DAY CENTER  
1 A BEECH ROAD  
ENFIELD, CT 06082  
(860) 763-7538  
Fax (860) 763-7584  
Email [Hvannucci@enfield.org](mailto:Hvannucci@enfield.org)

APPLICATION FOR ADMISSION

**FAMILY AND PERSONAL INFORMATION**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Marital Status:

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Name of husband or wife, if living: \_\_\_\_\_

With whom does the applicant live? \_\_\_\_\_

Your Children

Address

Tel. No (Wk.)/Hm.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Name and address of next nearest relative or trusted friend who could be contacted in an emergency:

\_\_\_\_\_  
Phone: \_\_\_\_\_

**Health History**

List any major operations or chronic illnesses or conditions you have experienced.

\_\_\_\_\_  
\_\_\_\_\_

Name, address and telephone number of physician(s):

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Choice of hospital: \_\_\_\_\_

Pharmacy Name & Number: \_\_\_\_\_

**Medicare**

# Part A \_\_\_\_\_

# Part B \_\_\_\_\_

Social Security No. \_\_\_\_\_

Other insurance coverage: \_\_\_\_\_

What assistance (if any) is required in the following areas?

<b>Area</b>	<b>None</b>	<b>Other, Explain</b>
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a. Walking, Standing	<input type="checkbox"/>	<input type="checkbox"/>
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b. Toileting	<input type="checkbox"/>	<input type="checkbox"/>
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c. Bathing	<input type="checkbox"/>	<input type="checkbox"/>
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d. Eating	<input type="checkbox"/>	<input type="checkbox"/>
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Dietary Requirements

a. regular diet ☐

b. low sodium ☐

c. diabetic ☐

d. other \_\_\_\_\_

Current Medications:

Dosage:

Times Given:

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Is supervision required? \_\_\_\_\_

Starting date: \_\_\_\_\_

Frequency: \_\_\_\_\_

Days: M ☐ T ☐ W ☐ TH ☐ F ☐

Transported by: Town ☐ Family ☐ Other ☐

Assistance required: \_\_\_\_\_

What special needs does the applicant have? (ex. Need for socialization, supervision, etc.):

\_\_\_\_\_

Name, address and phone number of individual or agency responsible for payment of Day Care services:

\_\_\_\_\_

\_\_\_\_\_

I, as caregiver, agree/do not agree to provide transportation to the Enfield Adult Day Center.

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

**Instructions:**

**Note:** Attach extra pages if more space is needed.

Print out the application, complete it and mail or fax to:

Enfield Adult Day Center  
1 A Beech Road  
Enfield, CT 06082

Fax (860) 763-7584

After the application is received, the Director will call and set up an appointment for you to visit the Adult Day Center and for the client to be evaluated. The client must have a physical and a 2-step PPD or chest x-ray before beginning to receive services through the Day Center.